(SPACE BELOW FOR FILING STAMP ONLY)

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Chapter 9 Counsel for Debtor Tulare Local Healthcare District

IN THE UNITED STATES BANKRUPTCY COURT

EASTERN DISTRICT OF CALIFORNIA

FRESNO DIVISION

In re TULARE LOCAL HEALTHCARE DISTRICT, dba TULARE REGIONAL MEDICAL CENTER, Debtor. Tax ID #: 94-6002897 Address: 869 N. Cherry Street Tulare, CA 93274	CASE NO. 17-13797 Chapter 9 DC No.: WJH-4 Date: Not set Time: Not set Place: 2500 Tulare Street Fresno, CA 93721 Courtroom 13 Judge: Honorable René Lastreto II

EXHIBIT TO DECLARATION OF DANIEL R. HECKATHORNE IN SUPPORT OF DEBTOR'S OBJECTION TO PROOF OF CLAIM NUMBER 197 IN AN UNSPECIFIED AMOUNT FILED BY THE DEPARTMENT OF HEALTH CARE SERVICES ON APRIL 6, 2018

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Exhibit	Description	No. of Pages
A	Proof of Claim No. 197 Filed by Department of Health Care Services	9

Dated: July 1, 2019

WANGER JONES HELSLEY, PC

By: Riley C. Walter

Riley C. Walter
Attorneys for Debtor Tulare Local Healthcare District dba Tulare Regional Medical Center

Fill in this information to identify the case:

Debtor 1 TULARE LOCAL HEALTHCARE DISTRICT dba TULARE REGIONAL MEDICAL CENTER

Debtor 2 (Spouse, if filing) _____

United States Bankruptcy Court for the: Eastern District of California

Case number 17-13797

FILED
APR -6 2018
UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF CALIFORNIA

Official Form 410

Proof of Claim

04/16

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**
   DEPARTMENT OF HEALTH CARE SERVICES
   Name of the current creditor (the person or entity to be paid for this claim)
   Other names the creditor used with the debtor _____

2. **Has this claim been acquired from someone else?**
   ☑ No
   ☐ Yes. From whom? _____

3. **Where should notices and payments to the creditor be sent?**
   Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

   Where should notices to the creditor be sent?
   Department of Health Care Services, MS 0010
   Name
   P. O. Box 997413
   Number Street
   Sacramento CA 95899 -7413
   City State ZIP Code
   Contact phone (916) 341-7345
   Contact email Steven.Oldham@dhcs.ca.gov

   Where should payments to the creditor be sent? (if different)
   Name
   Number Street
   City State ZIP Code
   Contact phone _____
   Contact email _____

   Uniform claim identifier for electronic payments in chapter 13 (if you use one):
   _

4. **Does this claim amend one already filed?**
   ☑ No
   ☐ Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**
   ☑ No
   ☐ Yes. Who made the earlier filing? _____

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**
☐ No
☑ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 2 8 9 7

7. **How much is the claim?** $ Undetermined at this time. **Does this amount include interest or other charges?**
☑ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**
Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).
Limit disclosing information that is entitled to privacy, such as health care information.

Overpayment of supplemental reimbursement under the Medi-Cal (California Medicaid) program. Supporting declaration attached.

9. **Is all or part of the claim secured?**
☑ No
☐ Yes. The claim is secured by a lien on property.

Nature of property:
☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim.*
☐ Motor vehicle
☐ Other. Describe: _____

Basis for perfection: _____
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $_____
Amount of the claim that is secured: $_____
Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amounts should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $_____

Annual Interest Rate (when case was filed)_____%
☐ Fixed
☐ Variable

10. **Is this claim based on a lease?**
☑ No
☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**
☐ No
☑ Yes. Identify the property: Equitable recoupment from Medi-Cal payments.

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☑ No

☐ Yes. *Check one:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$
☐ Up to $2,850* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$
☐ Wages, salaries, or commissions (up to $12,850*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$
☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$

* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☐ I am the creditor.

☑ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 04/05/2018
MM / DD / YYYY

Steven A. Oldham
Signature

Print the name of the person who is completing and signing this claim:

Name: Steven A. Oldham
First name Middle name Last name

Title: Senior Attorney

Company: Department of Health Care Services, Office of Legal Services
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: P. O. Box 997413, MS 0010
Number Street

Sacramento CA 95899
City State ZIP Code

Contact phone (916) 341-7345 Email Steven.Oldham@dhcs.ca.gov

EXHIBIT A

DECLARATION OF SHIELA MENDIOLA

- I, SHIELA MENDIOLA, declare as follows:

1. The following matters states in this declaration are true to my personal knowledge.

2. I am employed as the Section Chief of Medi-Cal Supplemental Payment Section, Staff Services Manager II, for the Safety Net Financing Division of the California Department of Health Care Services (DHCS). In that position, I oversee supplemental payment programs for the Safety Net Financing Division, and am a custodian of records for the Supplemental Reimbursement for Public Outpatient Hospital Services Program. I have been in my current position since January 2015.

2. California Welfare and Institutions Code section 14105.96 provides supplemental reimbursements under California's Medi-Cal (Medicaid) program for an outpatient department of a general acute care hospital that is owned or operated by a city, county, city and county, the University of California, or health care district, which meets specified requirements and provides outpatient hospital services to Medi-Cal beneficiaries. Supplemental reimbursement under the Supplemental Reimbursement for Public Outpatient Hospital Services Program reimburses for hospital costs that are in excess of the payments the hospital receives for outpatient hospital services from any source of Medi-Cal reimbursement.

3. Supplemental payments under this program to an eligible hospital are intended to allow federal financial participation for state certified public expenditures and follow the supplemental payment reimbursement and reconciliation methodologies described in Attachment 4.19-B, Section B, page 46-48 of California's State Medicaid Plan.

4. Final reconciliations are still pending for this provider for all program years beginning in State Fiscal Year 2002-03 until the bankruptcy filing in September 2017. A final reconciliation may result in a determination of overpayment or additional reimbursement (underpayment) for a particular year. The potential overpayment or underpayment determination amounts and timing for completion associated with the final reconciliations are unknown at this time.

I declare under the laws of perjury of the State of California that the statements in this declaration are true and correct.

Executed at Sacramento, California, April 5, 2018

Shiela Mendiola